

Transition from Methadone to Buprenorphine/Naloxone

Patient Education Module

Methadone is also a long acting opiate replacement and it recedes very slowly from the brain receptor sites. Buprenorphine has a higher affinity for opioid receptors. This means that it sticks like glue to the receptors in your brain, and if there is a methadone molecule sitting on an opioid receptor, the buprenorphine will toss it off, and put you into a precipitated withdrawal.

In order to decrease the chances of precipitated withdrawal setting in, it is recommended that you SLOWLY reduce your dose of Methadone to 30 milligrams per day. This is best achieved by tapering your methadone dose by 5 milligrams per week. Once you have reached 30 milligrams per day, you should remain at this dose for at least one week. After one week of 30 milligrams per day, you should completely discontinue methadone for at least 36 hours before starting Buprenorphine. You MUST be in mild to moderate withdrawal before you take your first dose of Buprenorphine. For some patients, this ideal situation may not be possible and the transition from methadone to buprenorphine will be much more difficult with a longer adjustment period.

In order to minimize the chances of a precipitated withdrawal, patients are given the mono-product buprenorphine without naloxone for anywhere from 2 to 4 weeks to allow a sufficient “wash out” period. Once you have made it through this “wash out” period, your doctor will further transition you to buprenorphine/naloxone.

Advantages of Buprenorphine Treatment Over Methadone Treatment

Due to its unique pharmacologic profile, buprenorphine has a number of advantages over methadone for use as an opioid replacement therapy. The following is a list of some of the major advantages of buprenorphine therapy:

1. Treatment does not require participation in a highly regulated federal program such as a methadone clinic, requiring daily doses.
2. Patients can be treated monthly, on an outpatient basis, in a primary care setting.
3. Patients are seen, evaluated, and examined by a doctor at each visit.
4. Buprenorphine allows the brain to start eventually producing its own natural opiates again and helps heal neurotransmitter and receptor sites.
5. Buprenorphine does not significantly prolong the QT interval, and is associated with less sudden death than is methadone.
6. Buprenorphine is a partial opioid and methadone is a full opioid.
7. Buprenorphine has less medication interactions.
8. Patients report that they feel less medicated and more normal, on buprenorphine as compared to methadone.
9. Since buprenorphine is a semisynthetic partial opioid agonist, it's easier to taper off of than methadone.
10. Buprenorphine treats a broader array of pain phenotypes than do certain potent mu agonists and is associated with less analgesic tolerance.
11. Buprenorphine does not cause hyperalgesia

12. Buprenorphine produces less constipation than methadone, and does not adversely affect the sphincter of Oddi.
13. Buprenorphine is effective for treating cancer pain.
14. Compared to methadone, buprenorphine showed *lower* severity of NAS symptoms, thus requiring *less medication and less time in the hospital*.
15. Buprenorphine causes less cognitive impairment than methadone
16. Buprenorphine is not immunosuppressive like other full opiate agonists, such as methadone.
17. Buprenorphine is effective for treating neuropathic pain.
18. Buprenorphine does not adversely affect the hypothalamic-pituitary-adrenal axis or cause hypogonadism.
19. Buprenorphine is a safe and effective analgesic for the elderly.
20. Buprenorphine is one of the safest opioids to use in patients in renal failure and those on dialysis
21. Withdrawal symptoms are milder and drug dependence is less with buprenorphine.
22. Buprenorphine has a ceiling effect on respiratory depression and is protective against overdose. The rate of overdose with methadone has increased by a factor of 7 since 1990. This is because there is no ceiling effect with methadone and patients can overdose from dose stacking.

Buprenorphine – A Unique Life-Saving Medication

The partial agonist effect of buprenorphine is *unique* to buprenorphine, and means that at a dose that effectively relieves craving, a ceiling effect prevents the euphoria associated with drug abuse and *protects against overdose deaths*. Buprenorphine can allow one to regain a normal state of mind – free of withdrawal, cravings and the drug-induced highs and lows of addiction and enable patients to get back to school, work, and family.

As a medication-assisted treatment, it suppresses withdrawal symptoms and cravings for opioids, does not cause euphoria in the opioid-dependent patient, and it blocks the effects of the other (problem) opioids for at least 24 hours. If a full opioid is taken within 24 hours of Buprenorphine, then the patient will quickly discover that the full opioid is not working – they will not get high. This 24-hour reprieve gives the patient time to reconsider the wisdom of relapsing with a problem opioid while undergoing medication-assisted treatment.

Why is Naloxone Added to Buprenorphine?

Naloxone is added to buprenorphine to decrease the likelihood of diversion and abuse of the combination product. Naloxone is not absorbed into the bloodstream to any significant degree when Buprenorphine/Naloxone is taken correctly by allowing it to dissolve under the tongue or in the inside of your cheek. However, if a Buprenorphine/Naloxone tablet is crushed and then snorted or injected the naloxone component will travel rapidly to the brain and knock opioids already sitting there out of their receptors. This can trigger a *rapid and quite severe* withdrawal syndrome. Naloxone has been added to Buprenorphine for only one purpose – to discourage people from trying to snort or inject it.